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ABSTRACT

This bulletin highlights topics addressed at a National Association of State Directors of Special Education (NASDSE) Action Seminar on Infants Exposed to Illicit Drugs and Alcohol in Utero. The incidence of babies being born exposed to cocaine and other illicit drugs is outlined, and it is concluded that numbers appear to be on the rise. The effects of illegal drugs on newborns are spelled out, and physiological causes of these effects are noted. Myths and realities in the effects of illicit drug use are identified. The need for joint coordinated efforts by several service agencies is discussed. Behavioral and academic strengths and limitations of these children, as determined from several research projects, are described. A list of recommendations pertaining to infants and children exposed to illicit drugs is presented. The bulletin concludes with NASDSE's statement to the House Select Committee on Narcotics Abuse and Control at a July 1991 hearing, and an excerpt from an amendment to the Higher Education Act Reauthorization related to training for teachers of drug-exposed children. (JDD)

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Children Exposed In Utero to Illegal Drugs: Education's Newest Crisis

Are Schools Prepared To Meet The Diverse Needs of the Children?

Each year since the mid-1980's, the population of children affected in utero by illicit drugs and alcohol appears to climb, and professionals in education, health, and human development concede much is still unknown about the children, their numbers, or the near- and far-term effects of their prenatal exposure.

Based upon experiences so far, experts from several disciplines generally agree that there are no "typical" profiles of drug-exposed infants, or children, or their families.

There is also consensus that outcomes for these neonates appears to depend, in part, upon the drugs or combination of drugs used by the mother and her specific reaction to them, the quantity used, and when during pregnancy the use occurred.

Healthy outcomes further are jeopardized by the mothers' lack of prenatal care, poor health behaviors, inadequate parenting skills, and chaotic and sometimes dangerous home environments to which the newborns could and do go after they leave the hospital. Postnatal neglect or abuse, whereby nurturing the baby is absent and physical and emotional needs go unmet, makes it difficult to single out the effects that drugs may have had on a developing fetus.

Many questions are yet to be answered about what constitutes the full range of appropriate interventions these children and families require and the degree to which existing agencies currently can determine and meet needs. While community health, education, child welfare, and social services systems all have a helping role to play, at times the agencies' missions may be competing or conflicting.

Beyond interagency concerns, educators have their own hard questions to face about the administrative structures and educational practices that will best serve these children and families. There is a rising voice not to stereotype these children or the interventions they need and to avoid labeling and separating the children solely on the basis of their prenatal exposure to drugs.

The following information highlights many of the topics addressed at a recent NASDSE Action Seminar on Infants Exposed to Illicit Drugs and Alcohol in Utero:

11% of All Babies May Be Affected in Utero by Cocaine

There have been no national studies completed that show the degree to which illegal drugs are used by pregnant women or accurate national counts of newborns affected by drugs in utero.

A frequently cited statistic is that 11% of all babies born, 375,000 babies born during 1991, are exposed to

This Liaison Bulletin it is based upon information collected from a variety of sources, including presentations made at three recent NASDSE Action Seminars in Washington, DC, Atlanta, GA and New York City.

The three year old Action Seminars program, made possible through technical assistance agreements with state education agencies, is designed to help professionals deal with compelling issues affecting the education scene. Participants hear from experts across disciplines, share experiences, and develop action plans or recommendations as part of their efforts to address emerging and powerful issues.

This Liaison Bulletin concludes with a statement provided by NASDSE to the House Select Committee on Narcotics Abuse and Control and excerpts from legislation passed in the House and pending in the Senate.

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cocaine and other illicit drugs. This was reported at NASDSE Action Seminars by Barbara Chamness of Childkind International and Evelyn Davis, a child development specialist and assistant clinical professor of pediatrics at Harlem Hospital Center in New York City.

Because testing of mothers and newborns is sporadic in maternity wards and infant nurseries, and without local or state reporting and tracking systems in place, claims about how many children make up this affected population amount to predictions based upon pilot projects or educated guesses, according to policy analysts at the U.S. Department of Human Services (HHS).

In their commissioned study of community programs serving drug-exposed children, urine toxicology screening, the primary identification tool for determining whether or not neonates are affected by drugs, as well as reporting procedures varied within and across cities. In other cases, HHS has learned accurate counts are further complicated because signs of maternal drug use or infant symptoms are incorrectly diagnosed or overlooked.

Numbers Appear To Be On The Rise

While numbers may be in question, there is consensus that children exposed to drugs in utero are on the rise and characterized by a wide range of problems that affect them medically, behaviorally, developmentally, and psychosocially. These may or may not be visible at first glance, experts argue.

Drug exposure before birth is a problem that crosses racial, ethnic, and socioeconomic backgrounds, a fact obscured by the populations for whom data is most readily available. Most comes from studies where the female subjects were recipients of public assistance and Medicaid, rather than privately insured patients. Hospitals apparently do not ask questions about illegal drug use or substance abuse of paying patients, noted a 1990 study by the General Accounting Office, an investigative arm of Congress. GAO was asked to look into the problem to guide lawmakers who are considering legislation at some future point.

Figures in that report (1990) estimated a range between 13 drug-exposed babies per thousand births in one hospital to 181 per thousand births in another. GAO's rate of one drug exposed baby in every 11 births in ten hospitals studied was higher than another statistic that is often cited from a National Hospital Discharge Survey that counted 13,765 drug-exposed infants born in all U.S. hospitals in 1988.

The GAO concluded that if testing were uniform and consistently applied, then numbers of drug-related births would surely be higher.

In addition, based upon information from child protective service agencies and health departments dealing with voluntary or mandatory referrals of drug-exposed children, HHS has learned that referrals of drug-exposed children are on the rise and have been since the mid-1980's, when crack cocaine became readily available to youth in America.

Without accurate estimates, agencies are unable to anticipate, plan for, and deliver appropriate services, officials argue.

Normal Or Not?

Many children who are drug-exposed seem normal at birth, experts note, and a large proportion of the children appear to have a normal IQ score, but with certain "developmental deficits." Some educators say the children are able to learn, but not necessarily in traditional ways.

Observable signs that have been attributed to a mother's drug abuse run a gamut from mild to severe. Problems can be motoric, such as tremors in the children's arms and hands as they reach for objects; or muscle tone, reflexes, and movement patterns that differ from unexposed infants. Prematurity and low birth weight are common, along with associated problems of cerebral palsy, chronic lung ailments, epilepsy, delayed speech, blindness and mental retardation. Researchers have reported that some children whose mothers took drugs during pregnancy are born shorter and with smaller head circumference, while others are characterized by seizures and even strokes.

In one analysis by HHS, nearly 30 percent of drug-exposed infants were born prematurely. In the larger group, only a small number showed gross physical problems. Many children were described as irritable and hypersensitive to stimulation.

Professionals have also reported that some of these babies avoid eye contact and respond negatively to dual stimulation, such as being rocked and talked to at the same time. They have been called difficult to console.

Techniques of care for these children differ from those that work with non-affected babies, according to one analysis by HHS. Caretakers in the neonatal nursery must have unusual amounts of patience and discipline. Professionals worry these attributes may be too difficult for mothers still addicted to drugs.

As they mature, some affected children seem to "outgrow" problems seen at birth, such as tremors, but they continue to show impaired abilities to concentrate, relate to peers in group settings, and cope with unstructured environment.

Physiological Causes

Pinpointing the effects of illegal drugs on a newborn is problematic because many factors influence a developing fetus. Female drug users are at high risk for complications before, during and after delivery, according to HHS reports.

Many studies that draw relationships between specific drugs and outcomes have design flaws and, thus, make inferences about causal relationships risky. More-

over, the same results or symptoms appear to stem from the use of different psychoactive drugs, notes a report from the Washington, DC-based National Center for Clinical Infant Programs.

And while mothers-to-be may state their preference for drugs of choice, they often take whatever drugs they can get mixed with other illegal or legal drugs such as alcohol and cigarettes.

Were this not confusing enough, the postnatal environmental experiences can compound the prenatal effects of drug exposure, which makes pure connections between a substance and later symptoms nearly impossible.

NCCIP explains that not all children exposed to drugs are born addicted. Some drugs are addictive while others are toxic. Still other are teratogenic, that is, they are known to result in serious congenital defects.

Physicians explain that in pregnant women, some drugs cross the placenta and have potential to harm their developing babies.

Of all drugs, the effects of prenatal exposure to alcohol is perhaps best known.

Fetal Alcohol Syndrome (FAS) is a disorder caused when pregnant women drink heavily. These children are characterized by nervous system dysfunctions, growth retardation, facial abnormalities, and mental retardation. While some problems improve over time, others don't, experts note. In school, children with FAS exhibit learning disabilities, hyperactivity, impulsivity, and antisocial behaviors.

Illegal And Other Drugs

Less well known are the effects of cocaine. In the studies cited in reports for HHS, cocaine use in a pregnant woman was said to cause hemorrhages, placental abruption, spontaneous abortions, premature labor and delivery, and fetal distress.

In affected infants, cocaine was at the root of increased likelihood of growth retardation, congenital malformations, and cardiac and central nervous system anomalies.

At birth, the drug-exposed newborns have shown abnormalities that include stiffness, irritability, frequent startling, irregular sleep patterns, and poor feeding. The long-term consequences of exposure to cocaine in utero are still under study.

Use by pregnant mothers of methamphetamines, marijuana, opiates and PCP, too, are harmful, to the infant in utero. Methamphetamine's effects are similar to cocaine except that newborns can be excessively sleepy and lethargic. Marijuana is associated with low birthweight or "small-for-gestational-age" infants, according to the report. The effects of PCP are nonspe-

Myths and Realities

Myth: There is an identifiable population of "crack kids" born prematurely, underweight, brain injured, unlovable and unteachable, with specific disabilities caused directly by prenatal drug exposure.

Reality: Conclusions about the effects of drug exposure are unavoidably confounded by a variety of environmental factors, including inadequate sleep and nutrition, family dysfunction, and poverty. *(Michelle L. Norris, 1991)*

Reality: Physiological damage depends on the amount, frequency, and timing of drugs used during pregnancy, as well as genetic and other biological factors which make some more vulnerable to prenatal exposure than others. *(The Future of Children, 1991)*

Reality: Many children exhibit neuro-behavioral immaturity but are not severely compromised. The development of these children depends as much on the "postnatal social environment" as on the prenatal exposure. (Marie Kanne Poulson, 1989)

Myth: Illicit drug use among pregnant women is an exclusively inner-city minority problem.

Reality: In a survey of women at 11 hospitals in Pinellas County, FL, 15.4% of White women and 14.1% of Afro-American women tested positive for drug use, regardless of the socio-economic status of the hospital's patient population. (NAPARE, 1989)

Reality: Minority women are 10 times more likely to be reported to child protective services for drug use. (NAPARE, 1989)

Myth: Prenatal exposure to illicit drugs like crack and heroin is a significant problem while legal drugs like alcohol and tobacco do not pose a serious threat to the fetus.

Reality: In Alameda County, California, which contains inner-city Oakland neighborhoods decimated by crack, only 10% of the low birth-weight babies born to African-American women are attributed to cocaine. (Petiti and Coleman, 1990, cited by Alan Trachtenberg)

Reality: At least 5% to 10% of all stillbirths and neonatal deaths are due to smoking in pregnancy. (De Haas, 1975; Meyer et. al. 1976, cited by Alan Trachtenberg)

Reality: Binge drinking (more than five drinks on any occasion) and drinking during the first two months of pregnancy are two of the strongest maternal predictors of later neurobehavioral defects among offspring. (Office for Substance Abuse Prevention, 1990)

Source: Elementary School Center [New York, July 1991]

cific, abnormal neurobehavioral problems. Babies exposed to opiates face newborn withdrawal.

Further complications arise when pregnant drug-abusing women engage in risky behaviors such as exchanging sex for drugs. This places them in jeopardy for contracting sexually transmitted diseases. Infants born with congenital syphilis, for example, face a shortened life span and other problems.

Drug-using women who engage in risk-taking behaviors and their developing babies are at risk themselves for human immunodeficiency virus (HIV) that can lead to Acquired Immunodeficiency Syndrome, which is nearly always fatal.

Late in 1990, the federal government's Centers for Disease Control noted that women made up about 10 percent of reported AIDS cases. Most cases of pediatric AIDS are the result of perinatal transmission from their mothers.

Joint Efforts?

While there is not yet agreement on the single best way to deliver services to individuals impacted by drugs, several experts point to a family approach as desirable when children are exposed to drugs prenatally.

As an ideal says experts in studies for HHS, drug-exposed children and their families require joint coordinated efforts by several agencies that have put in place administrative mechanisms for collaboration. Many believe the mother's problems must be given focus and that female interventionists should be part of the staff.

To be most effective, staff also should be trained so they are sensitive to both cultural differences and the poverty and drug-oriented life experiences of participating families. Cross agency training is expected to broaden professional knowledge beyond usual areas of expertise.

Yet, this may be easier said than done, researchers noted. They worry that organizational goals now stand in the way of effective service. Agency missions often differ and even conflict with each other, since some are mandated to protect children rather than preserve families, while others serve adults only to the detriment of family units. Few drug treatment programs can accommodate drug addicted women and children, for example.

Among obstacles in the commissioned study that Macro Systems conducted for HHS, no city studied had designated a "lead agency" to coordinate services, for example. Task forces were the most frequent mechanism used to mobilize providers around the problem.

In some cases, child abuse as related to maternal drug abuse drew attention, in part, when officials considered a proposed policy of prosecuting drug abusing mothers.

The lack of adequate assessment tools also stand in the way of determining who needs services. Moreover, eligibility criteria for developmental services can preclude drug-exposed children from receiving help unless their symptoms fit existing categories for service. The absence of long-term and flexible funding also stands as a barrier to service.

Educational Lessons

Since the mid to late 1980's, only a few educators have multi-year experiences serving drug-exposed children. While on one hand reports of pathology or deficits in children seem dire, the Chicago-based National Association of Perinatal Research and Education (NAPARE), under the direction of Dr. Ira Chasnoff, is following some 300 children whose mothers identified themselves as drug users during pregnancy. The oldest children are now three and four year olds. In July 1991, some 60 percent, who with their families are in treatment, were not showing developmental delays, according to NAPARE's Patricia O'Keefe, although some behavior and speech problems are present.

California teachers, in a four year old pilot program, note that some children whom they work with do have developmental delays or differences. Some children in the program have trouble developing attachments and dealing with multiple stimuli. While some are withdrawn, other children are overly aggressive, according to Judith Howard, director of the Suspected Child Abuse and Neglect Team at the University of California, Los Angeles.

Yet considered individually or as a group, teachers do not find the that these are a "new kind of children" never before seen in special education, notes Carole Cole, a teacher in that program. The best practices of education, special education, and early intervention still apply, Cole noted at a NASDSE Seminar.

Teachers can expect to deal with an array of behaviors, she warned, including strengths and limitations.

Harlem Hospital's Evelyn Davis suggests that the abnormalities with the greatest implications for school readiness are decreased attention span, perseverative behaviors, depressed problem-solving abilities, and inability to persist at a difficult task.

She cautions teachers also to expect some drug-exposed children to exhibit labile affect, uneven learning patterns, difficulty interacting with peers, trouble making transitions, inappropriate attachments, periods of "tuning out," receptive and expressive language delays, articulation disorders impulsivity, overreaction to stimuli and moodiness.

She noted recently that Harlem Hospital Center and the New York City Board of Education has developed an experimental early intervention, pre-school program emphasizing the family and community school. There, individualized attention is offered in a structured supportive environment enriched with language stimula-

tion and family support. Both the strengths and weaknesses of each child and family are given attention.

As for lessons learned thus far from these children, Los Angeles' Carole Cole advises that special and regular educators, if they haven't yet developed skills, become comfortable working with families.

This sometimes means avoiding judgments about dysfunctional lifestyles. She adds that teachers and other helping professionals listen more carefully for clues to what families want and need.

Cole says her experience leads her to believe that the children and parents are doing the best they know how. As a result she has rethought certain goals within special education. Making eye contact, for example, while an honest goal for many children, may be too stimulating for others, and so her focus is turned elsewhere.

She has also learned to expect parental relapse into drug abuse as sometimes part of recovery. She advises that teachers not give up when this occurs, but rely on other disciplines for better understanding and support. Schools cannot do the job alone.

Recommendations

Based upon the aforementioned information, the participants at the NASDSE Action Seminar generated a list of recommendations pertaining to infants and children exposed to illicit drugs:

1) Need to coordinate the development (policy-rules) and implementation of human services at the individual, community, state and national level.

2) Need to do a comprehensive public relations effort, at all levels, local, state and national, to make people aware of the conclusions.

3) Begin immediately to collect data on these children to serve as a basis for planning programs and training personnel.

4) Need to resolve legal and ethical issues before the courts do it for us.

5) Need to establish a universal all-inclusive system for sharing and networking information, solutions and failures.

6) Need to have educators get involved in the ongoing systems for data and information sharing that already exists across the country through other agencies and organizations.

7) Need to model the behavior (at the state level) that we want local providers of service to implement and meet the needs of the children and their families.

8) Need to insure that regular education personnel are aware of the existence of these children and what it takes to meet their needs.

9) Need to have NASDSE take a leadership role in demanding that language similar to that in PL 99-457 regulations be incorporated in the regulations governing federal programs administered by other state and local agencies to insure their participation.

10) Need to have state/local interagency coordinating councils become the forum to address the interagency needs of these kids and their families.

11) Need to do everything possible to not frame this issue as a minority or poor problem.

12) Need to be as conservative as possible in estimating the numbers of children needing services.

13) Need to train our special education staff on how to deal with and relate to other professionals in the education system.

14) Need to make recommendations within the State Education Agency to be aware of this population, their needs, how to meet them, and need to do this via the overall system so this does not become known as a special education problem.

NASDSE Statement to the House Select Committee on Narcotics Abuse and Control

The House Select Committee on Narcotics Abuse and Control on July 30, 1991 held a hearing peratining to the education of infants and children exposed to illicit drugs. At the hearing, William V. Schipper, Executive Director of the National Association of State Directors of Special Education, provided the following statement:

Mr. Chairman and members of the Select Committee, the National Association of State Directors of Special Education (NASDSE) appreciates the opportunity to present the following statement regarding programming for infants and children exposed in utero to illicit drugs and alcohol. Our membership includes the administrators of education programs for children with disabilities in the Departments of Education in the 50 States, the District of Columbia, and the jurisdictions.

Since 1988, our organization has taken an active role in bringing the plight of infants and children exposed to drugs and alcohol and their families to the attention of the educational community. During the past three years, achieving adequate and appropriate programming to address the needs of these children and their families has been one of our highest priorities. As part of that effort we brought together experts from the education and medical communities at national and state seminars, the most recent being in New York in May of this year, to develop policy recommendations and strategies that address this emerging critical issue. Our statement today reflects the thinking of those experts and incorporates several of the strategies recommended at those seminars.

Drug use in our society has reached epidemic proportions, affecting the lives of communities, parents and children throughout our country. The costs of this epidemic are high, and, as documented most recently in the excellent articles published by the *Washington Post*, are particularly dramatic for the babies and young children who are exposed to drugs before their birth. It has been documented that as many as 375,000 babies each year are born having been exposed to drugs while in utero. This translates to one drug exposed infant born every 90 seconds, and this may be a conservative estimate.

Reports from inner cities indicate that the national prevalence rate may actually be much higher. In New York City alone, it is estimated that there will be 72,000 drug exposed children by the year 2000. These numbers are only estimates, based on documented cases of fetal drug exposure. More accurate figures are not now available because of such factors as failure to report identified fetal drug exposure, pregnant women who do not seek prenatal medical care, and inconsistency in medical screening.

There appears to be little or no abatement in overall drug use in our country. Without stepped up prevention and follow-up interventions, we can expect the problems resulting from illegal drug use to continue long into the future.

Thirty percent of women between 18 and 34 years of age admit to a history of illicit drug use. It is imperative to understand that these women have no typical profile. It is a popular misconception that use of crack and other illicit drugs by women during pregnancy is confined to the Afro-American, Hispanic, and other minority populations in urban areas. This is simply not true; the problems of drug abuse cut across all socio-economic strata and racial groups. We are beginning to learn that drug abuse by middle and upper class women is substantial and increasing. However, we know less about the children born to these women, however, because they have better access to health care, are able to afford private medical services, do not need to interact with the public health system and, thus, are not as readily reported as drug users.

The long term effects of drugs and alcohol on children are not fully understood, and therefore, there is no agreement among physicians, educators, social workers, and human service professionals regarding the full impact of drug exposure on children. However, it is known that maternal substance use contributes to poor pregnancy outcomes.

A single dose of crack or cocaine in a pregnant women can cause the blood pressure at the placenta to rise five to ten times above normal. The effects on the fetus vary depending on individual circumstance, such as what point in fetal development such drug use occurs. We know, however, that the resulting problems often include extreme hyperactivity, uncontrollable mood swings, language delays, disorganized thinking, lapses in short term memory, poor coordination, difficulty with fine motor skills, and physical defects such as low birth weight, prematurity, decreased head circumference, and intestinal damage.

If as a nation we are going to adequately address this problem, there are certain fundamental concepts that must be fully understood and conveyed to policy makers, practitioners, and the general public:

1) Many children that have been drug exposed can lead fully productive lives given proper early intervention;

2) All children exposed to illicit drugs while in utero are not necessarily disabled as defined by the Individuals with Disabilities Education Act, and, therefore, are not necessarily in need of special education;

3) However, all children exposed to illicit drugs while in utero are at risk of experiencing developmental delays and life long complications and are in need of comprehensive, integrated interventions that include social, health, and educational services;

4) Failure to address the needs of these children and their families early on will result in greater costs to society; and

5) Emphasis on prevention activities, i.e. education about the risks associated with drug use, prenatal care, adequate nutrition, access to health care, and other human services needs to become a high priority relative in our country's war on drugs.

Infants exposed to crack cocaine, and other illicit drugs while in utero face a life of struggle not only because of the potential physical and emotional damage they may experience, but also as a result of societal perceptions. These children have been branded as the "Crack Babies," "Drug Babies," "The Lost Generation," "The Shadow Children," "Boarder Babies" and many other terms that convey a message of hopelessness and despair. These children are not hopeless and should not be written off. These children can fully participate in society and lead rewarding, fulfilling lives given the proper health care, social services, and educational interventions.

Our nation's schools will play a critical role in meeting the needs of children who have been exposed to substance abuse in utero. As described by other witnesses testifying today, a number of school districts, particularly in areas of high drug use, have already developed school-based programs specifically designed to provide services as early as possible to the first generation of such children.

Already, many of these children are finding their way into special education programs. Data indicate that the number of 3 - 5 year old children enrolled in special education in Los Angeles and Miami has doubled since 1986, and New York City last year alone saw a 26% increase in the number of 3 - 5 year old children in special education programs. We believe a substantial number of these children have been exposed in utero to drugs.

There is no question that many of these children will require special education and related services in order for them to succeed in schools. State and Federal laws require schools to provide free and appropriate public education to children with disabilities. This takes the form of special education, or specially designed instruction to meet the unique needs of a child with an identified disability, and related services that are needed to help a child with disabilities to benefit from their educational program. Related services include physical therapy, occupational therapy, counseling, and transporation, but not medical services except for the purposes of evaluation and diagnosis of an educational disability.

A significant number of children may not require special education and related services but will continue to be identified as in need of special education because other services and help may not be available. Others will not qualify, but will be at-risk of failure in school.

Our schools need to be prepared to meet the diverse needs of all children who come through their doors, including the growing number of children exposed prenatally to drugs and other forms of substance abuse. While some of these children will require specially designed instruction through special education programs, others will demonstrate less severe educational problems and will require special attention within the general school program. Educational programming by the schools is a necessary part of services that are needed by the children we are talking about today; but alone it is insufficient to meet their broader needs.

There is no single solution to the complex, escalating problem of substance abuse, but we are sure of what will not work. As you may know, the special education system like other human services has evolved into a categorical program with specific eligibility criteria and funding designated for a targeted population. Yet many of the infants, children, and youth served in special education also need and receive services from the health, mental health, social service, and welfare systems.

Where children are well served, service systems have worked out the difficulties of coordinating their efforts and focus their interventions on the needs of the child, often within the context of the family unit. When service systems operate independently from each other, constrained by differing eligibility criteria, restrictive

funding streams and sometimes conflicting program requirements, we see fragmentation and duplication of services, inefficient use of scarce resources, and complex bureaucracies that make accessing needed services a nightmare for the child's family or guardians. All too often, the maze of State and Federally funded programs, categorically oriented to address the needs of a particular population, make such coordination at the local level a difficult challenge for service providers.

States and communities are confronted with the task of collaborating and coordinating services across diverse agencies and funding sources to the meet the needs of infants and children, yet are constrained by a lack of programmatic and funding flexibility. In order to engage the States in a partnership with the Federal government in developing and improving services for children exposed to drugs, we would caution against enacting narrowly defined legislation that limits, rather than enhances, the ability of States to respond creatively to the problems their citizens are experiencing. If the needs of these children are to be appropriately addressed, states will need assistance in developing comprehensive, coordinated, multidisciplinary, interagency services at the local levels.

Over the last five years, the Federal government has been engaged with States in an effort to develop such a system of support for infants and toddlers with disabilities through Part H of the Individuals with Disabilities Education Act, administered by the U.S. Department of Education. In 1986, Congress enacted PL 99-457 which authorized a formula grant program to assist States in establishing a statewide, comprehensive, coordinated, multidisciplinary, interagency system to provide early intervention services for infants and toddlers with disabilities and their families. Federal support for this program was intended to provide the resources necessary for the planning and coordination of such a system across existing programs and services at the State and local level. Under the Part H program, all States have developed an interagency coordinating council to oversee the development of the service delivery system and, within about two years, all States hope to be providing early intervention services to all eligible children on a statewide basis. I stress the term hope, because the financing of this early intervention system in many States is proving difficult. The limited Federal funding for Part H is intended for planning and coordination activities; State and local revenues are supposed to pay for the actual delivery of early intervention services to children and families. At present, resources within many of the States are not adequate to finance service delivery.

An important component of this legislation pertains to infants and toddlers who do not have disabilities but are at risk of having substantial developmental delays. We know that many infants and toddlers that have been exposed to illicit drugs in utero do have substantial impairments qualifying them for Part H services; many others are at-risk of experiencing developmental delays, and therefore may not necessarily receive appropriate intervention. Under the curent statute, states retain the right to determine eligibility criteria for early intervention services and therefore have the option to serve at-risk children. The lack of fiscal resources has inhibited states from doing so. When Congress authorized the Part H Program in 1986, it was envisioned that 100,000 - 160,000 eligible infants and toddlers would be served. Given the prevalence of infants exposed to cocaine and other illicit drugs, as many as 300,000 - 375,000 infants and toddlers might also be eligible to receive these services. While Part H programs in the States are creating the systems of service delivery that can address the early intervention needs of young children, at this time resources are inadequate to provide such services to all children who might benefit from them.

The National Association of State Directors applauds your attempt to address the needs of these infants and children. You can be assured that special education provided by the public schools for children age 3 and above, and early intervention services for infants and toddlers with disabilities and their families will play an important role in each State in meeting the needs of children exposed prenatally to illegal drugs. However, these types of services designed for children with disabilities are insufficient if we are to maximize the potential of these children and minimize the effects of their mothers' drug use.

A proposal we feel would make significant and positive contribution to increasing States' ability to serve these children and their families has been introduced this year in the Senate. This proposal, the Children of Substance Abusers Act (COSA), has recently been folded into S. 1603, the Alcohol, Drug Abuse and Mental Health Block Grant. The COSA proposal would support the development in States of comprehensive and coordinated health, developmental, and social services to families where substance abuse is present, while providing States the flexibility needed to apply Federal funds to needs within their own service delivery systems.

Under this bill, services would not be limited to children exposed to drugs in utero, but would also be directed to children whose parents or guaridans abuse drugs and alcohol. The bill requires community-based service delivery and encourages the maintenance of family structures by providing home visiting services. The COSA proposal also establishes a much needed training program for professionals that work with these children. At present, the COSA legislation does not have a sponsor in the House. We encourage you to carefully review this bill and consider taking the leadership on it in the House.

We would also urge this Committee to consider how the Federal government can assist States and communities in accessing the information they need to faciliatate their prevention efforts as well as to assist them in the identification of children in need of services and to develop services and interventions that are needed. While increasingly available particularly through the schools, information and education for children, families, educators, and health care professionals regarding the effects of drug exposure is still insufficient. A particular problem exists in reaching high risk populations who do not access health care or other public services which could provide information about the prevention and effects of substance abuse on children. Further, educators and others at the State and local levels need to know about the experiences of others who have successfully developed programs for children exposed to drugs and their families. They need to know what works, how they have put together effective services, and what is required to do so.

So that other communities around the country do not have to reinvent the wheel, so to speak, it would be particularly helpful to capture and describe successful experiences and to make this information widely available to the education, health and social service networks operating at the national, State and local levels. To do this, support is needed, first to identify and describe what works and under what conditions in diverse settings, and second to package this information in usable forms for professional organizations, clearinghouses, and other entities that are actively engaged in exchanging information about successful practice with their constitutents in the field. Organizations like ours for example have in place mechanisms for sharing information about effective practice with our members who, in turn, can work with established networks in their States. Other professional organizations in health, education and social services have similar mechanisms.

If we have access to information about how best to meet the needs of children who have been exposed to drugs in utero, we assure you we will use every means possible to disseminate it broadly and to use it in working with our colleagues in other fields to promote the collaborative relationships needed to improve services at the State and local levels, as well as to infuse such knowledge into the professional training programs of our universities and organizations.

We appreciate the opportunity to provide input to you on the needs of infants and children exposed in utero and whose parents abuse alcohol and drugs. We welcome your efforts and leadership, and offer to you our assistance.

HOUSE MOVES TO AMEND TITLE V OF THE HIGHER EDUCATION ACT

During October 1991, an amendment to the Higher Education Act Reauthorization was passed by the House Education & Labor Committee. Similar language is found in a bill pending Senate action. The House amendment and excerpts from the accompanying Report Language follow:

This amendment addresses the crisis faced by schools as thousands of peri-natally drug-exposed children enter America's education system. In introducing the amendment on behalf of himself and Rep. Charles B. Rangel, Rep. Owens incorporated recommendations he received while participating in Select Committee on Narcotics hearings...

The goal of this amendment is to improve educator's skills and access to information regarding intervention strategies for drug-exposed children. The $15 million authorization would provide grants to schools of education so that they may develop training programs for students of education and educational personnel and it creates an information clearinghouse on the subject of drug exposed children.

Subpart 8 — Training for Teachers of Drug-Exposed Children

SEC. 594. PROGRAM AUTHORIZED

(a) **GENERAL AUTHORITY.**— From the funds appropriated to carry out this subpart, the Secretary may make grants to schools of education at institutions of higher education to support the development and instruction in the use of curricula and instructional materials that provide teachers and other educational personnel with effective strategies for educating drug-exposed children. In selecting schools for receipt of grants under this subpart, the Secretary shall give priority to schools located in or near communities with a large number or rate of —

(1) arrests for, or while under the influence of drugs;
(2) infants born prenatally exposed to drugs;
(3) drug-exposed children of preschool or school age; or
(4) a significant drug problem as indicated by other appropriate data.

(b) **CONDITIONS FOR GRANT ASSISTANCE.**— Any recipient of a grant under this section shall agree, as a condition to receipt of such grant, to disseminate the curricula and materials with funds provided under this subpart by either or both of the following methods:

(1) Instruction of teachers and other education personnel from schools within the State in which the grant recipient is located.

(2) Designation of personnel of the grant recipient to serve as consultants to such schools for the dissemination of such curricula and materials.

(c) **CLEARINGHOUSE.**— (1) The Secretary shall establish a clearinghouse to compile and make available the curricula and instructional materials developed with funds provided under this subpart. The clearinghouse shall make available—

(A) implementable curriculum plans for educational personnel in classroom and other school settings;

(B) curriculum plans for schools of education in institutions of higher education that describe drug-exposed children's characteristics and strategies for educating drug-exposed children; and

(C) other information concerning the characteristics of drug-exposed children and effective strategies for educating such children.

(2) The Secretary shall consult with the Secretary of Health of Health and Human Services concerning the curricula, materials, and information to be made available through the clearinghouse. The Secretary shall effectively notify State and local educational agencies concerning the availability of such curricula, materials, and information from the clearinghouse.

NASDSE Publishes Updated IDEA

NASDSE is pleased to announce plans to publish an updated, complete version of the ***Individuals with Disabilities Education Act***, as amended by P.L. 102-119 (October 7, 1991). This update will be available on or about February 1, 1992, and will contain all amendments to the Act passed during the first session of the 102nd Congress. These amendments include changes enacted in the Part H and Section 619 Programs, as well as all other amendments to date.

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If youhave any questions or need further information, please contact Toni Warmack at the NASDSE Office.

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